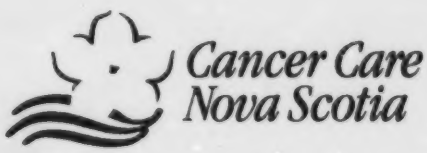
SUMMARY REPORT

from

Cancer Care in Our Communities:
A Roundtable Discussion

June 7, 2000
Holiday Inn
Dartmouth, Nova Scotia



PREFACE

On June 7, 2000, ***Cancer Care Nova Scotia*** hosted a Roundtable Discussion called *Cancer Care in Our Communities*. Over one hundred people involved in some way with Nova Scotia's cancer system met to discuss ways to make the system more community-based.

This report contains a summary of the discussions that were held during the Roundtable, including a summary of the feedback that we received on the first draft of a proposed District Cancer Model. In addition, the proposed District Cancer Program Model has been revised based on the feedback from the Roundtable participants, and a second draft is now available in a companion document for review.

The Roundtable was the first of what we expect will be many conversations among cancer system stakeholders to help ***Cancer Care Nova Scotia*** coordinate, strengthen and evaluate cancer services in Nova Scotia. Based on the evaluation forms received after the Roundtable, participants welcomed the opportunity to work collaboratively to develop a new model of cancer care, as well as the opportunity to meet and learn from their colleagues from across the province. We would like to take this opportunity to thank all of the Roundtable participants for their hard work and excellent feedback.

The fall of 2000 promises to be busy as we seek input on the second draft of the District Cancer Program Model, and begin visiting the various health districts to discuss implementation of the model. We want to emphasize that we will continue to work collaboratively with our many partners in cancer care throughout the province. We are confident that by working together, we will succeed in bringing cancer care closer to our communities.

Sincerely,

Andrew Padmos, BA, MD, FRCPC
Commissioner, *Cancer Care Nova Scotia*

Peggy Davison
Board Chair, *Cancer Care Nova Scotia*

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SECTION ONE:
Introduction

Cancer Care Nova Scotia

Cancer Care Nova Scotia is a program of the Nova Scotia Department of Health, founded in 1998. We have a mandate to co-ordinate, strengthen and evaluate cancer services in Nova Scotia through integrated prevention, education and treatment programs. All programs are evaluated on the basis of being community focused, patient-centred, cost-effective and based on solid evidence.

Cancer Care Nova Scotia has developed its action plan around three strategic goals:

- To have high quality, standardized cancer care across the province
- To reduce cancer incidence and premature mortality rates
- To implement a high quality, multidisciplinary cancer research program.

The mission, values and vision of ***Cancer Care Nova Scotia*** may be found in Appendix One.

Why A Roundtable Discussion?

In keeping with the ***Cancer Care Nova Scotia*** motto "Many Hearts, Many Minds, One Goal," we are always striving to find ways of working effectively with our many partners in cancer care. The Roundtable discussion was developed as part of our collaborative approach to improving the cancer system, and our desire to find effective mechanisms of communicating with the many people involved in cancer care throughout the province.

The Roundtable was held on June 7, 2000, and was attended by 111 cancer care providers, volunteers, researchers and cancer survivors. The agenda of the Roundtable was determined by the results of a needs assessment conducted several months before the meeting (see Appendix Two for a summary of the needs assessment results). Throughout the day, Roundtable participants engaged in open dialogue with their colleagues from around the province to:

- offer suggestions to improve a draft model for community-based cancer care in Nova Scotia;
- begin thinking about how a community-based model of cancer care could be implemented within their own District Health Authority; and
- identify common cancer system issues, and mechanisms for all stakeholders to be involved in addressing the issues.

Using a facilitated process, most of the Roundtable meeting was devoted to small group discussions around the three key theme areas listed above.

After a few brief presentations in the morning, participants addressed the first theme by working in groups whose members came from diverse backgrounds and geographic locations. The second and third theme areas were discussed in the afternoon. For these discussions, participants were grouped according to the District Health Authority in which they work. The agenda for the Roundtable is in Appendix Three.

We recognize that not all people are comfortable in raising their concerns or issues in a small group setting, so participants were offered the opportunity to complete an "Individual Comment Form" which they could submit with their evaluation form. The form simply asked for the topic area of concern, and the individual was invited to write down their concern. The information from the fourteen forms received is presented in Appendix Four.

Sixty-six participants completed and returned evaluation forms at the end of the Roundtable meeting. The response from participants was very positive, with many respondents indicating that they appreciated the opportunity for dialogue and networking. A summary of the evaluation forms is in Appendix Five.

The Roundtable Report

This report is a synthesis of the valuable work completed by participants on the day of the Roundtable meeting. Section Two of the report is an overview of all of the contributions made to improve the draft district cancer model for community-based cancer care.

Section Three focuses on the first steps required to implement district cancer programs, and who in each district needs to be involved in planning the program. The information in this section is presented by District, so that when implementation planning begins in each District, the planning team will have a summary of issues relevant to their district.

Section Four contains a summary of common issues that need attention throughout the cancer system, and potential mechanisms to engage all cancer system stakeholders in addressing the issues.

Section Five contains copies of the presentations that were given during the Roundtable meeting.

Commitment to Next Steps

All of the input to the draft District Cancer Program Model has been used to prepare a second draft of the model. The second draft will be shared with all Roundtable participants, and others who are involved in the cancer system, to allow for a second round of comments and suggestions for improvement. A third working draft of the District Cancer Program model will be prepared in the fall of 2000.

Cancer Care Nova Scotia will work with District Health Authorities and people involved with the cancer system in each district, to determine the best mechanisms for implementing the model across the province. It is expected that while the basic framework of the model will be consistent across the province, actual implementation may vary greatly in different districts depending on local community needs. Section Three of this report will serve as a useful starting point for the discussions that need to be held in each district.

Cancer Care Nova Scotia will ensure that the items identified during the discussion about common cancer system issues receive priority for development of action plans. We will also strive to implement some of the mechanisms that participants suggested are necessary to support collaborative action to address the issues. In particular, the organization of future Roundtable meetings, development of a public report card, and implementation of a web-site are mechanisms that we will focus on in the coming year.

We hope this Roundtable will prove to be the beginning of a united effort that ultimately strengthens and enhances the cancer system in Nova Scotia.

SECTION TWO:
Improving the Proposed District Cancer Program Model

One of the main purposes of the Roundtable was to explore a draft model for a district cancer program model. After brief presentations about models in other provinces and the draft model proposed for Nova Scotia, participants were asked to discuss and record:

- what they liked and did not like about the draft model,
- gaps in the model; and
- parts of the model that need to be changed.

To simplify the presentation of all of the information generated by the fourteen small working groups, it has been divided into two main parts:

- what participants liked about the proposed model, and
- how the proposed model can be improved.

All of the recorded information from the working groups was transcribed from the flipchart pages in to a word processing file. Common themes across all of the data were identified and any theme that was supported by three or more working groups was noted as a priority for consideration in the next draft of the district cancer program model.

The remainder of this section of the document provides an overview of the priority themes that emerged during the first working session of the Roundtable.

What Participants Liked About the Proposed District Cancer Program Model

Care closer to home

Almost all groups (12 of 14) stated that one positive feature of the model is the opportunity to provide care closer to patients' homes, reducing the amount of travel time required to receive treatment. Almost all groups liked the emphasis that the model places on standards for treatment, education, and continuity of care.

Province-wide plan

Eleven groups stated that they liked the fact that ***Cancer Care Nova Scotia*** is attempting to implement a province-wide plan. There is a strong sense that a system is needed to pull together the many pieces of cancer care throughout the province. Participants saw the draft model as a good first step toward a comprehensive provincial cancer system.

Comprehensive Approach

Half of the groups stated that they liked the comprehensive approach of the model (i.e. the fact that it includes everything from prevention to palliation). Some groups stated that this comprehensive approach will improve continuity of care.

Prevention and screening

Six groups commented that they liked the fact that prevention and screening were included as part of the model.

Other themes (stated by between 3 and 5 groups) that emerged from the discussion about what participants liked about the proposed model include the:

- fact that the model builds on existing services and programs;
- emphasis on professional education;
- community focus of the model;
- roles of ***Cancer Care Nova Scotia*** as champion, advocate, quality monitor, and builder of partnerships;
- multidisciplinary team approach; and the
- ability of the district program to respond to local community needs and concerns.

How the Proposed Model Can Be Improved

Enhance patient-centered focus

Ten or more groups noted three major issues needing improvement in the proposed model. The first is the need to reduce the medical focus of the model, to make it more patient-centered and more multidisciplinary in nature.

Increase emphasis on health promotion

The second major change that needs to be incorporated into the model is an increased emphasis on health promotion, prevention and screening. One group suggested that everything from standards development to funding formulae must include a dedicated component for health promotion.

Change membership of District Cancer Committee

The third issue that requires a significant change in the proposed model is the membership of the District Cancer Committee. Different groups suggested different changes to the membership of the Committee, including more community representation, reducing the provider-focus of the Committee, and including representation from non-institutional programs and services.

Between five and eight groups listed the following changes to the proposed model:

- clarify how resources will be allocated to the District Cancer Programs;
- include a stronger definition of how and where palliative care fits into the model;
- increase the emphasis on the role of support in the model; and
- address issues for low-income patients and families.

Three or four groups suggested that each of the following need to be considered when re-drafting the model:

- the role of volunteers in the model needs to be clarified;
- need to develop realistic indicators and outcome measures, as well as effective reporting mechanisms;
- the model may not strengthen integration across disease sectors, so more linkages are needed with other programs (e.g. diabetes);
- more patient and family involvement is needed in decision-making;
- need a time line;
- need a mechanism to change historical referral patterns; and
- the accountability relationships of the District Cancer Committees need to be clarified.

Patient-Centred

After the working session that produced all of the information highlighted above, a reporting back session was held to allow participants to hear about the discussions held by groups other than their own. It was observed during the reporting back session that while many groups talked about the need for the model to be "patient-centred", there was little clarity about what the phrase meant in terms of the practical application of a model for the health system.

The facilitator invited groups to discuss this issue as part of the afternoon working sessions. However, because the issue is directly relevant to the proposed model, the results of the discussions held about the phrase "patient-centered" are presented here.

Defining "patient-centred"

In response to the question "What does patient-centered mean?, groups generated a number of responses that fall under six main themes:

- informed choice (7 groups);
- holistic (4 groups);
- patient identifies their own needs (4 groups);
- put patient first (3 groups);
- includes family (3 groups); and
- respect (for patient values, for differences) (3 groups).

Making the model patient-centred

In addition to the above descriptions of the concept of "patient-centred", eight groups noted how the proposed model can reflect this concept, including:

- continuity of care;
- ease of access;
- patient navigation; and
- organizing services around patient needs.

SECTION THREE:
Ideas for Implementation

After spending the morning discussing the proposed District Cancer Model, participants returned in the afternoon to begin discussing how a District Model might be implemented in their District Health Authority. Specifically, working groups discussed these questions:

- Who in your District needs to be involved in developing a community cancer plan?
- What are the roles of the people/organizations that need to be involved?
- What are the first steps to implementing a community cancer model in your District?

Participants were organized into working groups by District, so some groups were larger than others. A few participants representing provincial organizations were randomly assigned to a District. In one case, two Districts combined to form one group, and in the case of District 9, there were several groups due to the large number of participants from this area. In total, there were 13 working groups for this session.

Working groups generated a significant amount of important information during this session that will be extremely useful as implementation of District Cancer Programs begins. To ensure that the implementation issues of each district are not lost in a synthesis of the working session, the work of each working group is presented separately in this section of the report. ***Cancer Care Nova Scotia*** will refer to the work of each working group as we begin discussions in each District about implementing the proposed model.

Ideas for Implementing a District Cancer Model In *District One*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Getting stakeholders together to raise awareness of ***CCNS*** and proposed plan (would CHB's coordinate this with ***CCNS***; role of ***CCNS*** to get the message out in collaboration with identified stakeholders).
- Develop strategic plan – goals and objectives, action steps (timeframes), budget; ensure volunteers/professionals have necessary education.
- More training for CCS volunteers.
- Establish District Cancer Committee – keep this small and workable.
- Identify strengths/weaknesses/gaps of the district.
- Build on what exists.
- Ensure proper communication and consultation with community.
- Physical support – transportation, beds in patient's homes, delivery.
- Access to necessary care and services when required (not waiting).
- What patients say they want/need.
- Community consultation. Identify strengths/weaknesses/gaps, build on strengths.
- Build in true community participation.
- Evaluation.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Patients/families.
- Canadian Cancer Society.
- Home Care.
- VON.
- Home Support agencies.
- Private nursing agencies.
- Palliative Care.
- Chemotherapy program – South Shore Regional, Queen's General.
- Community services.
- First nations.
- LTC sector.
- Local pharmacies.
- District Health Board.
- Community Health Boards.
- Well Women's clinics/health fairs.
- Hospital social workers (4 in region).
- Heart Health.
- Volunteers.
- Clergy.
- Support groups – adult grief, bereavement.
- Public Health – RN, dietician.
- ***CCNS***.
- Complementary therapists.

- Physicians – linked with chemo program, palliative care. GP's, surgeons, visiting pediatrician.
- Hospital representation – space, health records, finance, dietician.

Roles of the Individuals/Organizations That Need to be Involved

Canadian Cancer Society:

- Financial assistance.
- Emotional support.
- Home health aids.
- Health promotion/education.

Palliative Care:

- Need earlier involvement.
- Pain and symptom management.
- Emotional support (volunteer component).
- Equipment loans.
- Education.
- Liaise with hospital/community agencies.

Home Care/VON/Home Support/LTC:

- In-home care and support.
- Respite care.
- Referrals/liaison.

Physicians:

- First contact.
- Treatment.

Hospitals:

- Chemotherapy program (well-defined):
  2 RN's
  5 days/week
  Support
  Strong links with CCS
- Surgeons/internists.
- Well-supported by community.
- 2 dieticians – 1 hospital-based, 1 output.
- Social worker.
- Chaplain – volunteer.
- Surgery.
- Investigation/diagnostics.
- Well Women's clinics.
- Refers to QEII and IWK for oncology services.
- Administration, finance, medical records.

CCNS:

- Funding.

- Leadership.
- Development of standards.
- Education – orientation.
- Developing navigator role in collaboration with others.
- Quality management.
- Public relations.
- Advocacy – healthy public policy.

DHA/CHB's:

- Understanding and support of ***CCNS***.
- Funding.
- Accountability.

Community Services:

- Financial support – transportation.
- Referrals.

Pharmacies:

- Health care aids/supplies.
- Education.
- Preparation of specialty medications (unique issue to Western Region) i.e. pick up prostate meds from pharmacy and take to hospital/doctor for administration.

District One Group Members
Janet Carver
Bonnie Eagle
Vicki Elliot-Lopez
Hubert MacDonald
Joan MacDonald
Jill Petrella

Ideas for Implementing a District Cancer Model In *District Two*

First Steps To Begin Implementing A Community Cancer Model in Your District

- 3 CSM's advertise for members for 2 groups.
- Communicate with ***CCNS*** regarding model and consultation for community.
- Community consultation regarding model.
- Develop strategic model based on balanced score card:
  - Resource Management
  - Service Quality
  - Learning and Innovation
  - Satisfaction
  - Collect data
- Develop IT linkages with telehealth to involve all sites in planning process.
- Continued dialogue with ***CCNS*** and DHA.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Must have a special interest in cancer.
- Representative from ***CCNS***.
- Home care.
- Clergy.
- Persons who are affected by cancer – from each CHB area.
- Representative from Canadian Cancer Society.
- Palliative Care.
- Representative from oncology committee.
- Care provider – from each CHB area.
- Inclusive of visible minorities.
- Community services.

Roles of the Individuals/Organizations That Need to be Involved

- District 2 Cancer Care Roundtable.
- Patient centered focus.
- Accessibility.
- Prevention.
- Navigation.
- Information/education.
- Needs assessment.
- Acceptability.
- Quality monitoring.
- Communication with ***CCNS*** and DHA.

- Prioritization.
- Clinical Oncology Committee.
- Standards/guidelines.
- Human Resources.
- Funding.
- Data collection.
- Service provision.
- Measurement – effectiveness.
- IT services.
- Similar to District Cancer committee list.
- Needs site representation.
- Roundtable representative.

District Two Group Members
Lynda Casey
Nan Holden
Shelagh Leahy
Claudia Lutz
Brent Powers

Ideas for Implementing a District Cancer Model In *District Three*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Provision of generic matrix by ***CCNS*** and CCS, updated from today's discussion.
- Clarity of roles.
- Town Hall meetings in all districts regarding a new plan. Facilitated by ***CCNS*** and CCS.
- Then modify the matrix to serve community needs.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Site Manager.
- Front line staff.
- Mental Health.
- Home Care Nova Scotia: VON.
- Volunteers and staff: other health groups.
- Link with academic community.
- Public health.
- Chief of Staff.
- Physician.
- Patients and survivors (CCS).
- CCS volunteers and staff.
- DHA.
- Geographic representative.
- Health care providers.
- Chaplain.
- Pharmacists.
- Social workers.
- CHB's.
- Palliative Care.
- Multicultural/minority groups.
- General public.

Roles of the Individuals/Organizations That Need to be Involved

- Planning.
- Advisory.
- Monitor.
- Advocacy.

District Three Group Members

Tricia Cochrane
Louise Cottreau
Ethel Ells
Jane Farquharson
Belle Grant-Fairn
Lloyd Graham
Doug Henshaw
Earle Hiltz
Kathryn Rawding
Marguerite Rowe
Nora Stephen
Elizabeth Tappen

Ideas for Implementing a District Cancer Model In *District Four*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Coordinating existing groups and services.
- Evaluating effectiveness and finding gaps.
- Planning.
- Inform/educate CEO of DHA.
- Meet with management of DHA as soon as in place.
- Present to DHA board orientation in September, 2000.
- ***CCNS*** board meet/communicate with DHA board.
- ***CCNS*** management meet with DHA management.
- Care provider to care provider.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Chemo Nurses.
- Surgeons.
- Pharmacist.
- Radiologist.
- Canadian Cancer Society.
- Pastoral care.
- Provincial professional association.
- ER Nurses.
- Long term care facilities.
- ***CCNS.***
- Informal community leaders.
- Community Services (Social Services).
- Palliative Care Nurse/MD.
- Pre Op Assess Nurses.
- Home Care/VON.
- Pathologist.
- Clients, family, survivors.
- Alternate health providers.
- 1st Nations community.
- Social Workers.
- Nutritionists.
- CHB's.
- Schools.
- Local service clubs.
- Family physicians.
- IWK/Grace.
- Medical Society Nova Scotia.
- Internist.
- Existing support and volunteer groups.
- Community facilities.
- African Nova Scotians.
- DOH.
- DHA's.
- Politicians.
- Youth groups.
- OT/PT.

Roles of the Individuals/Organizations That Need to be Involved

- Promote.
- Educate.
- Advocate.
- Network.
- Keep up-to-date.
- Support.
- Facilitate.
- Document.
- Evaluate.
- Flexible plan.
- Coordination.

What is the role of the family physician?

- Primary care physician.
- Need to redefine what primary care is.
- Clarify role and authority of ***CCNS*** vs. DHA.

Other Discussion

- DHA will want decision making power.
- Time and implementation progress of DHA may influence the development of DCM.
- Local providers of cancer care may need to take on implementing DCM during transition from RHB to DHA.
- Need dedicated resources (human and fiscal, mainly people) to DCP.
- Need critical patient and family mass to provide competent care.
- Clearly define roles of primary, secondary, tertiary services and process for determining them.
- Need IT system.
- Advocacy and education role of CCS, volunteer groups, community groups.
- Role of patient/family is accepting responsibility, within limits, as they desire. Need education and support. Need to make wants and needs known to hospital.
- Patient needs to make sure system knows what their goals/expectations are.
- Role of hospital is to listen to the patient, provide information and to know how involved in decision making the patient wants to be and which decisions they want to be involved in. Hospital has to be open to communication with patient family.
- Regional Hospital role – diagnosis, prevention/screening, acute treatment, supportive care, coordination of care.
- Development of standards – ***CCNS***.

- Monitoring of standards – tertiary, regional, and community.

District Four Group Members
Nancy Archibald
Michelle Landry
Kathy Little
Shaun MacCormick
Anne Murray
Martha Underwood

Ideas for Implementing a District Cancer Model In *Districts Five and Six*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Goal identification.
- Role clarity – who does what?
- Develop implementation committee.
- Critical path – what's in place now and how to support.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Client/consumer/ survivor.
- Representative from CHB's, one from each.
- GP/specialists/palliative care/diagnostic services.
- DHA representative.
- Regional oncology service.
- Community support groups – Palliative care, volunteer, Cancer Society.
- Facility managers.
- Pharmacy.
- Nursing.
- Support services – Pastoral care, social workers, mental health, PT/OT.
- HCNS.
- Clinical navigator.
- Community health/public health.
- QEII.
- Representatives from cultural demographic.
- ***Cancer Care Nova Scotia.***
- IWK/Grace.
- Information systems.

Roles of the Individuals/Organizations That Need to be Involved

CCNS:
- Advocacy.
- Competence standards.
- Provincial leadership and coordination.
- Monitoring outcomes measurement.
- Educational standards.

Cancer Site Teams:
- Standardization of care.
- Clinical Practice Guidelines.

DOH:
- Funding support to Information Management.
- Identifying "Care Programs".

DHA:
- Implementation/accountability (standard of care).

QEII, IWK/Grace:

- Tertiary Care – unusual cancers (specialized cancer), radiation, consultation and direction, research trials.

CHB:

- Monitoring primary health performance data and making recommendation to DHA.
- Community needs assessment.

Districts Five and Six Group Members

S.L. Barclay
Krista Burrill
Joanne Cumminger
Gerry Farrell
Patrick Flinn
Andrea Gardner
Dennis MacDonald
Patricia MacEwan
Elizabeth MacLean
Jim Meikle
Debbie Oliver
Sheila Scaravelli

Ideas for Implementing a District Cancer Model In *District Seven*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Focus group educates about ***CCNS*** initiatives, community-based cancer care.
- Working group.
- Public and professional awareness, communication strategy.
- Needs assessment to identify resources, gaps, etc.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Patients, families/significant others and survivors.
- Palliative care.
- Oncology providers.
- Physicians (surgical, medical, oncology, PC).
- Regional Hospital head.
- Community representatives.
- Preventative care, public health, CCS.
- HCNS – long term care reps.
- Pastoral ministry.
- Health records rep.
- Interdisciplinary team reps, care providers.
- CHB, DHA reps, population health.
- Hospital/community and PC Societies.
- Facility managers.
- Ethicist.

Roles of the Individuals/Organizations That Need to be Involved

- Advisory, support, education.
- Coordination.
- Present issues, identify gaps.
- Support, provide clinical perspectives.
- Communication, networking.
- Community, facility and group linkage.
- Identify resources.
- Keep focus on patient/client.
- Advocacy.
- Prevention.
- Increase public awareness.
- Service provision.

District Seven Group Members
Nancy Cameron
Kaye Marie Chisholm
Mary Foshay
Karen Hoben
Heather Jewers
Jane MacLeod
Elaine MacMaster
Charlene Porter
Rose Richardson
Mary Ross
Pauline Samson

Ideas for Implementing a District Cancer Model In *District Eight*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Raise awareness of the District Cancer Model in the community.
- Stakeholder group needs to come together. Roundtable facilitated by ***CCNS*** after model fine-tuned.

Those Who Need to Be Involved In Developing a Community Cancer Plan

Principles:

- broad based, cancer expertise (includes providers/science),
- community variation (broad scope, cultural diversity),
- accessibility,
- expertise and systems – drugs/transport (i.e. financial support, education).

Who:

- CCS, staff and volunteers.
  - Build on existing models, don't reinvent the wheel.
- Rural representation/geographic coverage (i.e. Western side of the island).
- Regional/tertiary – Cape Breton Cancer Centre/CBRHC.
- Cape Breton Wellness Centre – patients with prevention mandate.
- Multidisciplinary – social work, dieticians, etc.
- Funders/administrators/ ***CCNS.***
- Home care.
- Survivors.
- Scientific expertise, in the broad sense – data relevant to community (sociologists).
- Community Health Board linkage.
- First Nations/Acadian, cultural diversity.
- Community leaders – buy-in/trust/respect (i.e. service organizations).
- Palliative care.
- Ensure committee structures reflect facility involvement, which will be responsible for service delivery and care provider input.
- Objective consumer – not with cancer or medical background.
- District Health Authority.
- Specialist providers – oncologists, nurses, others.
- Family physicians.
- Seniors input – use existing groups.

Roles of the Individuals/Organizations That Need to be Involved

Advisory Role:

- Area of expertise and expert knowledge.
- Patient/direct care.
- Psychosocial support.
- Prevention – primary, secondary.
- Local concerns.
- Scientific.
- Information gathering – needs assessment, inventory of existing resources including funds in the system.

Planning:

- Working from advice and needs assessment to develop a plan for cancer requirements in the community.
- Prioritization.
- Impact – analysis including financial resources.

Education:

Regarding health determinants particularly as it relates to cancer.

Other discussion

Setting goals

- Outcome measures (i.e. defined treatment plan and path for each patient diagnosed with cancer).
- Consistent communication standards.
- Reduce time from diagnosis to definitive treatment.
- Improved system access.
- Clear points of entry.
- Timely access to diagnostic/screening tests.

District 8 Group Members
Rod Beresford
Beverely Braunmiller
Dianne Grant
Jeslyn Hendsbee
David MacDonald
Maureen MacIntyre
Clare MacQuarrie

Ideas for Implementing a District Cancer Model In *District Nine* *(Group One)*

First Steps To Begin Implementing A Community Cancer Model in Your District

- What is already there and working (i.e. palliative care, Cancer Society, home care).
- Local hospital – use its resources.
- RHA/DHA – provide specific information to districts of resources, health plans, where will services be delivered.
- Clear decisions first don't ask for input if decision has already been made.
- Tumor Board for prioritization/treatment.
- Patient, advocate.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- New Capital Health Board (set direction).
- Local hospitals.
- Palliative care.
- Pharmacy.
- GP/FP.
- Community services.
- Home care.
- Clergy.
- Patients/families.
- Tertiary hospital, oncology.
- CCS.

Roles of the Individuals/Organizations That Need to be Involved

- Communication coordination.
- Education/PR – equal treatment.
- Nurse practitioners.
- DOH $.
- Regional Boards (priorities).
- Community care coordinator (accesses all local resources).

District 9, Group 1 Members
Sandre Decaire
Lyn Frankton
Christine Heggelin
Mary Frances Moriarty
Mary Russell
Carol Smillie
Shaun White

Ideas for Implementing a District Cancer Model In *District Nine* *(Group Two)*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Process facilitated by ***CCNS***.
- Invite participation of broad cross section of collaborative partners to establish a planning team.
- Identify resources and assets currently available – inventory and measure against model.
- Identify components of community cancer plan model and establish process time frames.
- Identify issues/resources and related gaps/deficiencies/challenges and determine methods to address and to develop community-based consensus.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Canadian Cancer Society – emotional support, health promotion.
- Community Health Boards.
- Community/Regional Hospitals (multidisciplinary).
- ***CCNS.***
- Multicultural reps.
- Long term care facility.
- Department of Health (senior representatives).
- Palliative Care.
- Patients.
- GP's/Physicians.
- IWK/Grace.
- Clergy.
- NS Department of Community Services.
- District Health Authorities.
- Home Care.
- Family/supporters.
- Cancer Site Teams (multidisciplinary).
- QEII Cancer Centre.
- Social workers.
- Health Profession Faculty/Schools.
- Multidisciplinary health promotion and screening (Health Charities Network).

Roles of the Individuals/Organizations That Need to be Involved

- Inventory/description of current resources.
- Identification of anticipated needs – clinical/support/community.
- Identification of resources gaps – clinical/support/community.

- Confirm clinical practice guidelines and evaluate regarding resources.
- Develop system for monitoring compliance/clinical practice.
- Incorporate/confirm patient/family navigation process.
- Facilitate a community-based communications program about development and implementation of community plan.
- Advocate/ombudsman role for patients/families regarding any aspect of patient experience.

District Nine, Group 2 Members
Ann Cogdon
Ginny Cronin
Elizabeth Cooper
Peggy Davison
Shirley MacLeod
Linda Muir
Judy Simpson
Linda Verlinden

Ideas for Implementing a District Cancer Model In *District Nine* *(Group Three)*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Clarification of what is the capital health district.
- Roundtable exercise in each community.
- Provincial government responsibility?
- Roundtable would lead to a planning committee/process.

Those Who Need to Be Involved In Developing a Community Cancer Plan

For primary and secondary care:

- Third party insurers.
- Community Health Boards.
- Hospital-based health professionals business (health delivery e.g. home health products).
- University.
- Government.
- GP's, community-based health professionals required to meet needs.
- Representation – across the continuum of service delivery.
- Hospital, home, and community long term care settings.
- Patients and families.
- Advocacy groups.
- Primary prevention.

For tertiary care:

- Need additional involvement from a provincial perspective.

Roles of the Individuals/Organizations That Need to be Involved

CCNS

- Leadership – coordinating organizations around issues (i.e. IT).
- Advocating on issues that affect cancer care, as well as other issues.
- To be "a voice", to keep the cancer agenda "front and center".
- To see and bring a broader perspective from other programs, up-to-date knowledge.
- Keep accurate information (registry) on which programs can be based.
- Keep up-to-date "resource" information (website).

- Establish communication links, with district and CHB's.
- Quality management systems (a framework).
- Disseminate information to regions, along with analysis and interpretation.

District/Community Health Board

- Take the lead in "ownership" of the program.

Patient and Family (experienced)

- To participate.
- Bring the perspective of the consumer to hold health professionals accountable.
- To contribute/to develop a "charter of expectations".
- To help health professionals in understanding needs.

District 9 Group 3 Members
Elizabeth Barker
Gail Bruhm
Bruce Crump
Deborah Grant
Mary Ellen Gurnham
Cathy Logan
Karen Mann
Bonnie Salsman

Ideas for Implementing a District Cancer Model In *District Nine* *(Group Four)*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Identify the players.
- Identify what they can bring to the program.
- Find out from the players what they feel are the gaps in the system and public policy.
- Be conscious of the barriers of health care within the district.
- Question where community-based care should take place.
- Should tertiary care hospital provide community-based care – barrier?
- Reinvolve family doctors in patient's care from the beginning of their treatment.
- Identify communities and their needs within the central district. Recognize what the CHB has done to identify these areas.
- Confirm whether or not there needs to be more than one DCC.

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Religious leaders.
- Pathologists.
- Family Caregivers Association of NS (volunteers).
- Antipoverty groups.
- Oncology nurses.
- Primary prevention collaborations.
- Pharmacists.
- Patients.
- Pediatric cancer program.
- Family doctors.
- Radiologists.
- AIDS coalition – gay/lesbian transgender advocates.
- Central Community Health Boards.
- Social workers.
- Health charities relevant to cancer care.
- Dietary.
- Family members.
- Physiotherapy.
- Surgeons and oncologists.
- Palliative care.
- Literacy coalition.
- CCS units.
- Screening programs.
- Research – nurses, doctors, etc.
- Seniors groups.
- Survivors/long term survivors.
- OT.

Roles of the Individuals/Organizations That Need to be Involved

- Ensure input that the system is accessible.
- Develop standards of care.
- Ensure well rounded, holistic standards.
- Effectively manage who can document on patient's chart (i.e. type of information collected on chart).
- To ensure all patients needs are being met.
- Each member listed previously needs to bring their expertise to the model.
- Ensure proper linkage between members (i.e. family doctors and oncologists/cancer centre).
- Patient advocacy.
- Ensure seamless delivery of care as well as education and information. Ensure "no cracks to fall through".

District 9 Group 4 Members
Bonnie Howstrauser
Anne Miller
Jeffrey Nguyen
Jennifer Parker
Annette Penny
Kimberly Pitts
Len Reyno
Dianna Schreuer

Ideas for Implementing a District Cancer Model In *District Nine* *(Group Five)*

First Steps To Begin Implementing A Community Cancer Model in Your District

- Set up committee.
- Define terms of reference, mandate, objectives, and goals.
- Provincial cancer care system needs to be clearly defined and understood.
- Define existing resources and build/enhance what exists.
- Establish priorities.
- Community focus groups.
- Communication and education to communities (i.e. media).

Those Who Need to Be Involved In Developing a Community Cancer Plan

- Patient and family.
- Family/community/specialist/doctor.
- Nurses.
- Pharmacists.
- Social workers.
- Dieticians.
- Clergy.
- Home care.
- Palliative care.
- Reps from agency providing care.
- Volunteer sector (i.e. CCS, VON, etc.).
- Reps from CHB.
- Special interest groups.
- Multidisciplinary oncology teams who bring expertise.
- Ethnic groups/socioeconomic/geographic representation.

Roles of the Individuals/Organizations That Need to be Involved

- Understand needs and develop programs.
- Development of a holistic patient centered approach at the community level.
- Case management/coordination.
- Ensure individuals receive a continuum of care: prevention - palliation.
- Partnerships, navigation, integration, coordination and evaluation.
- Education on all levels (public, patient, health professionals).
- Advocacy.
- Public policy.
- Ensuring quality care.
- Standard development.
- Resource identification and allocation.

District 9 Group 5 Members
Charlotte Ackerman
Ann Hopkins
David Jones
Janet Knox
Ann Marie Maloney
Debbie Muise
Victoria Sullivan
Gordon Thomason

SECTION FOUR:
Working Together on Common Issues

One of the points made by many people who responded to the pre-Roundtable needs assessment, was the need to spend time at the Roundtable discussing effective ways for participants to work together on common issues affecting the cancer system across the province. During the third working session at the Roundtable, small working groups discussed the following questions:

- what are the common cancer system issues that we need to address collectively
- what are the mechanisms by which your voice may be heard in the discussion about common issues; and
- how do we engage all players in action on common issues?

To simplify the presentation of information from this working session, the responses from working groups have been divided in to two categories:

- summary of issues common to all cancer system stakeholders; and
- ways in which individuals and organizations may participate in addressing common issues.

Summary of Common Issues

Fiscal and Human Resources

Nine of thirteen working groups stated that the lack of fiscal and human resources is a common issue that needs attention. It was suggested that we cannot improve one area of the health care system at the expense of another, and that implementing a new model of cancer care will require an investment of time and energy from already very busy people. It was also noted that there is no money available for the type of education suggested in the proposed model.

Patient and Provider Education

Six working groups specifically stated that education for patients is an issue across the province, and five working groups stated that education for health professionals is a common issue as well. It was suggested that patients need better education through the continuum of cancer care, including education about prevention, screening, diagnosis, and options for treatment and support. Cancer care health professionals need education that includes refresher courses, new technology, new information, community resources and the role of palliative care.

Prevention, Navigation, and Access

Each of the following are issues common across all Districts (stated by at least six working groups):

- patient navigation;
- coordination of prevention activities; and
- equitable and timely access.

Three to five working groups identified the following as common issues:

- development of standards and clinical practice guidelines;
- support for patients, families and caregivers;
- communication with patients and families;
- palliative care; and
- information technology resources.

Ways to Support the Participation of Individuals and Organizations in Addressing Common Issues

Future Roundtable Meetings

The most frequently stated means of engaging people in dialogue and action on common issues was holding future Roundtable meetings. This was stated by six of thirteen working groups, and by many individuals who completed evaluation forms at the meeting (a summary of the participant evaluations is in Appendix 5).

Reporting to Communities

Five working groups suggested that there is a need to report back to communities on the progress being made in cancer care, through community newspapers, radio, and television. Four groups specifically identified the need for a public report card.

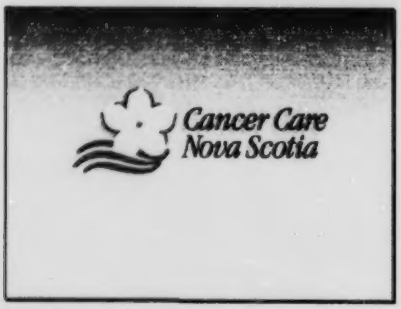
Using Technology

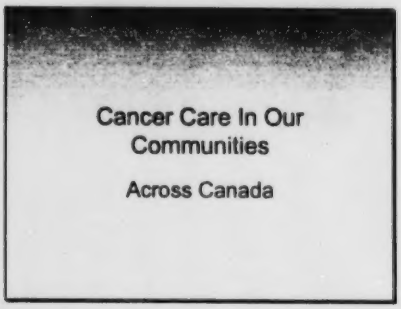
Five groups suggested that technology should be used to facilitate communication, such as an interactive web-site, e-mail and telehealth.

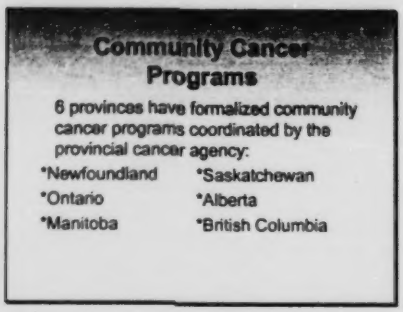
Other mechanisms for involving stakeholders suggested by three or four groups are use of community focus groups and use of a 1-800 telephone number. Three groups specifically stated that formal mechanisms of communication need to be developed among cancer system stakeholders, and another three groups stated that stakeholders need to be involved in decision-making.

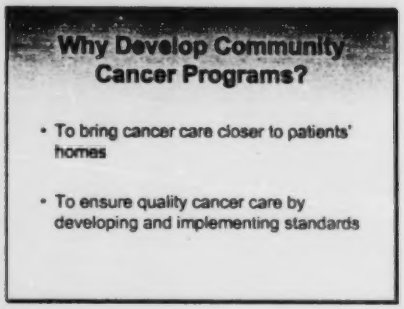
SECTION FIVE:
Presentations and Speaking Notes

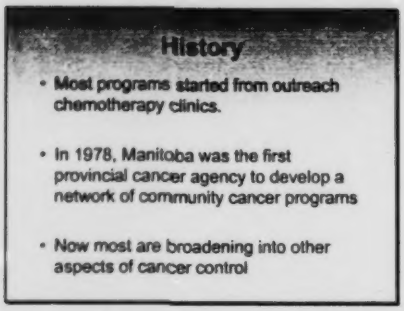
Cancer Care In Our Communities: Across Canada
Presentation by Jill Petrella, Quality Coordinator,
Cancer Care Nova Scotia

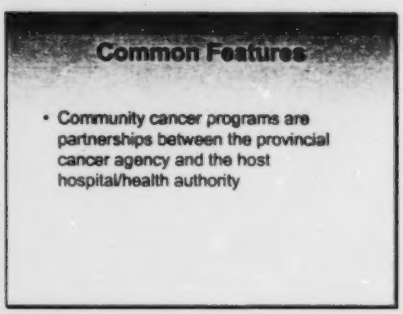


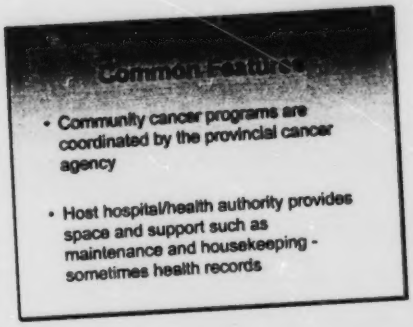


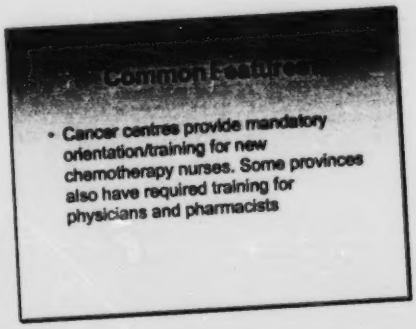


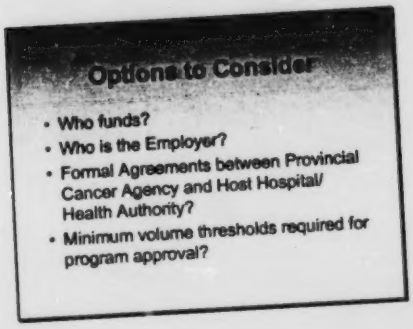

Why Develop Community Cancer Programs?
• To bring cancer care closer to patients' homes
• To ensure quality cancer care by developing and implementing standards

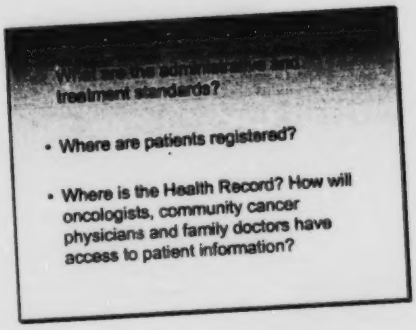

History
• Most programs started from outreach chemotherapy clinics.
• In 1978, Manitoba was the first provincial cancer agency to develop a network of community cancer programs
• Now most are broadening into other aspects of cancer control

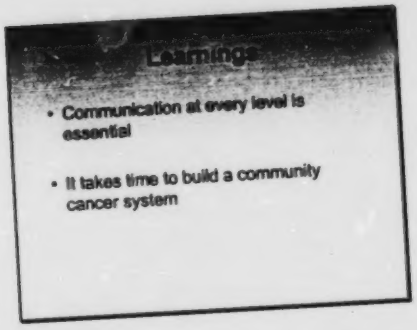

Common Features
• Community cancer programs are partnerships between the provincial cancer agency and the host hospital/health authority

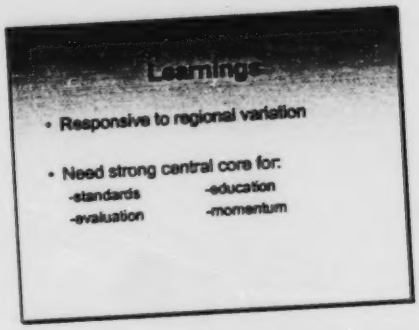

Common Features
• Community cancer programs are coordinated by the provincial cancer agency
• Host hospital/health authority provides space and support such as maintenance and housekeeping - sometimes health records

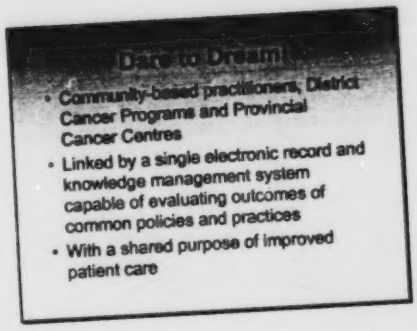

Common Features
• Cancer centres provide mandatory orientation/training for new chemotherapy nurses. Some provinces also have required training for physicians and pharmacists


Options to Consider
• Who funds?
• Who is the Employer?
• Formal Agreements between Provincial Cancer Agency and Host Hospital/ Health Authority?
• Minimum volume thresholds required for program approval?


treatment standards?
• Where are patients registered?
• Where is the Health Record? How will oncologists, community cancer physicians and family doctors have access to patient information?


Learnings
• Communication at every level is essential
• It takes time to build a community cancer system


Learnings
• Responsive to regional variation
• Need strong central core for:
-standards
-education
-evaluation
-momentum


Dare to Dream
• Community-based practitioners, District Cancer Programs and Provincial Cancer Centres
• Linked by a single electronic record and knowledge management system capable of evaluating outcomes of common policies and practices
• With a shared purpose of improved patient care

Cancer Care
Nova Scotia

Cancer Care in Our Communities: A Proposed Model for Nova Scotia

Presentation by Andrew Padmos, Commissioner, Cancer Care Nova Scotia

Cancer Care Nova Scotia

District Cancer Program

Why?

- Fundamental to an evolving provincial cancer system
- Enables best practices
- Builds on existing strengths
- Ensures standardized, quality care province-wide

District Cancer Program

Why?

- Equitable access to cancer care across the province
- Availability of common core cancer services in each health care district
- Provision of services according to provincial standards

District Cancer Program

Current Proposal

- Draft for Discussion
- Expect feedback from you and others to help develop the concept further

District Cancer Program

Who	System	Individual
Public	Accountability	• Prevention • Screening
Patients & Families	Standardized Care	• Treatment • Support
Providers	Standards	• Education • Support

District Cancer Program

Who Provides the Care?

- Physicians (surgeons, family doctors, internists, oncologists from cancer centres)
- DHA staff (nurses, pharmacists, support staff)
- Other health care providers in the District

Many of these are already involved in cancer care

District Cancer Program

What will they offer?

Primary and secondary cancer care closer to patients' homes

- Awareness
- Education
- Prevention
- Early detection
- Diagnosis
- Staging
- Elements of treatment
- Support
- Rehabilitation
- Continuing care
- Palliation

District Cancer Program

Where will they be located?

- Every health care district
- "Head-quartered" at Regional Hospitals
- Services would be provided throughout the District wherever standards can be met (e.g. regional and community hospitals, community health centres, physicians' offices, patients' homes)

District Cancer Program

When will they begin?

- Pilot implementation to begin Fall 2000
- Phased implementation
- Start with existing resources allocated to cancer services within the District
- Initial focus will be on standardizing existing treatment services (i.e. PMSTP and CPGs)

District Cancer Program

How will they work?

Collaboratively

Internally
- District Cancer Committee
- DHA
- CHBs
- Patients/Families/ Survivors
- Providers

Externally
- Other DCPs
- *CCNS*
- Provincial Cancer Centres
- Cancer Site Teams

District Cancer Program

How will they work?

- Formal agreements between ***CCNS*** and District Health Authorities
- Using common standards (e.g. CPGs, ACCC etc)
- District Cancer Committees (DCC) provide guidance and coordination
- Medical leadership
- Staff coordinator

District Cancer Program

Role of District Cancer Committee

- Coordinate operational aspects of cancer program delivery
- Coordinate implementation of, and compliance with, provincial standards
- Identify local cancer priorities and issues
- Collaborate in development of provincial priorities and standards

District Cancer Program

CARE DELIVERY

Prevention/Screening

Diagnosis

Treatment
- Primary/Secondary Care
- Support and Rehabilitation
- Continuing Care
- Family Support
- Palliative Care

Education/Research

ADMINISTRATION

Cancer Committee
- Human Resources
- Resource Allocation
- Support Services
- Planning
- Quality

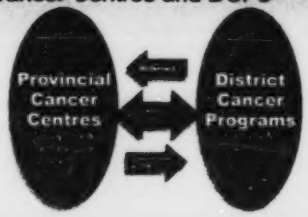
- Accountable for quality of patient care; efficient and appropriate use of resources
- Participate in processes which will develop provincial system/ standards(e.g. Roundtable; representation on ***CCNS*** Board)
- Employ DCP staff

- Provide space and support services (e.g. housekeeping, maintenance etc) to DCPs
- Maintain DCP budgets
- Determine what services to offer and where to offer them, as long as minimum standards are met.

- Treatment
  - assessment and appropriate follow up of all NS oncology patients
  - tertiary treatment for all patients
  - provide specialist staff for outreach clinics
  - secondary treatment for local patients and patients who can't access what they need from own DCP

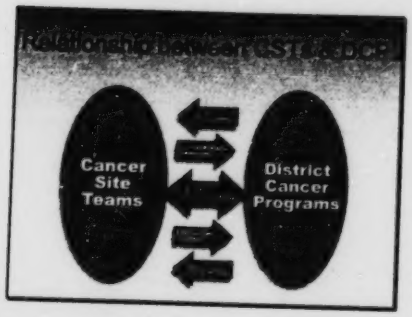
- Consultation/Support to DCP staff
- Education
  - health professional students
  - continuing professional development for DCP staff
- Research
  - promote
  - coordinate
  - conduct

Relationship between Provincial Cancer Centres and DCPs



- Multi-disciplinary teams of professionals, volunteers and patients with a common focus on cancers arising in a particular body system or site.
- Provincial in scope and membership
- *CCNS* provides technical and process support

- Develop Clinical Practice Guidelines for provincial use
- Lead case conferences with DCP participation via Telehealth
- Provide education to DCP staff



Focus

- Ensure standards (e.g. clinical, staffing, education) are established and met
- Lead development of provincial information systems linking DCPs and Cancer Centres
- Coordinate continuing professional development programs for cancer professionals

Facilitate

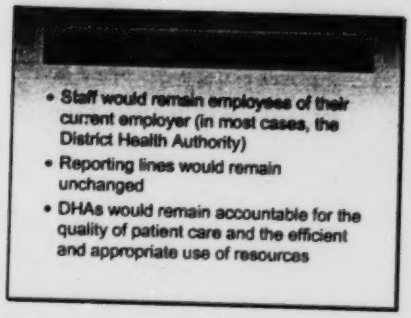
- Communication among DCPs and with ***CCNS***
- Development of each DCP
- Collaboration with other provincial programs (e.g. HomeCare Nova Scotia) and link with DCPs

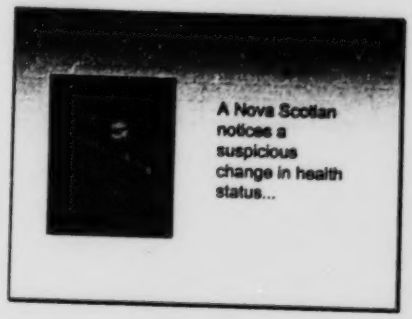
Fund

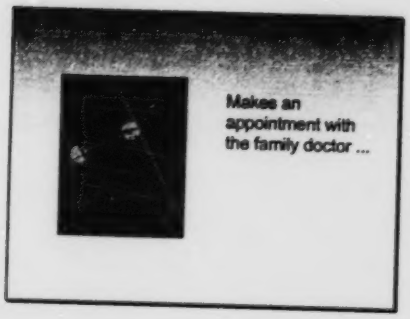
- Advise Department of Health on cancer services, including cancer budget allocations
- ***CCNS*** will work with DHAs to develop multi-year business plans for DCPs

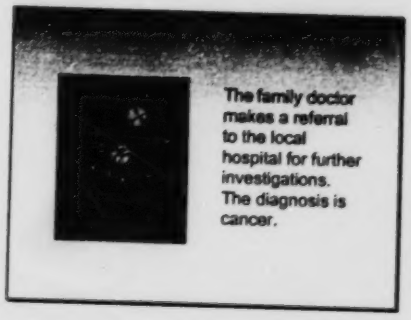
- ***CCNS*** would advise the Department of Health on the funding for cancer programs and services for each DHA.
- Cancer funding currently part of global budgets would be identified

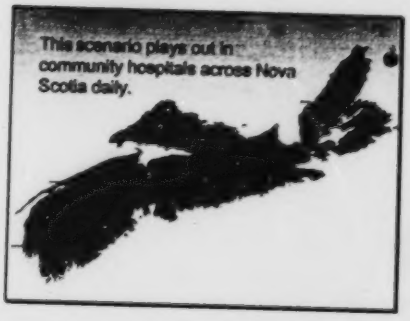
- Clinical Practice Guidelines, PMSTP and other standards will improve provision of care
- The development of provincial standards may result in service delivery changes

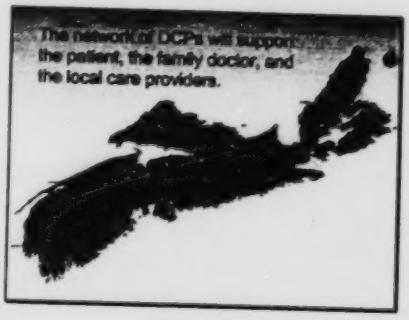

• Staff would remain employees of their current employer (in most cases, the District Health Authority)
• Reporting lines would remain unchanged
• DHAs would remain accountable for the quality of patient care and the efficient and appropriate use of resources

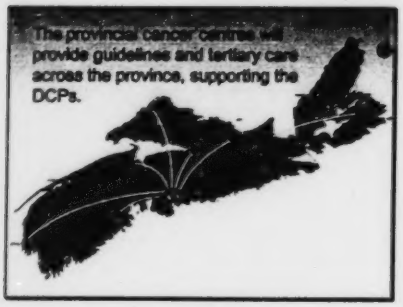

A Nova Scotian notices a suspicious change in health status...

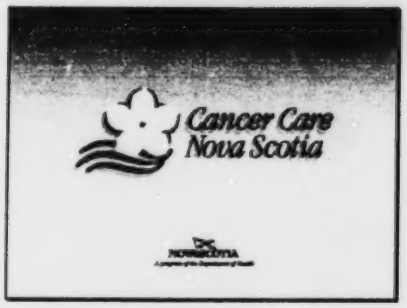

Makes an appointment with the family doctor ...


The family doctor makes a referral to the local hospital for further investigations. The diagnosis is cancer.


This scenario plays out in community hospitals across Nova Scotia daily.


The network of DCPs will support the patient, the family doctor, and the local care providers.


The provincial cancer centres will provide guidelines and tertiary care across the province, supporting the DCPs.


Cancer Care
Nova Scotia

Presentation by Mr. Patrick Flinn, Hospital Administrator, Aberdeen Hospital, New Glasgow

Speaking Notes

We at the Aberdeen Hospital, New Glasgow in Pictou County have had the opportunity to review an early draft of the proposed District Cancer Program. We like what we see. But before I go further, let me give you some background.

Background

For some years now the Aberdeen Hospital has been operating a chemotherapy program. We have competent nurses, pharmacists and physicians who are at the centre of the program. They work very closely with the patients, their families and the physicians involved. Through the establishment of the District Cancer Model we see an opportunity to build on our success and assure our clients and ourselves that we are providing comprehensive, quality driven cancer care. We see a partnership with ***CCNS*** and the QEII that will lead to improved delivery of treatment.

Developments to Date

Representatives from ***CCNS*** and the QEII Oncology Program visited our hospital in early April and presented and early draft of the District Cancer Program. We provided our comments and concerns and I am pleased to say that they have been reflected in the revised proposal.

During that visit they also made the offer to set up a visiting clinic. Since then a Medical Oncologist has been named for our clinic; he has conducted a site visit to discuss the organization of the clinic process and procedures; and has conducted a CME session with our physicians.

My point here is that things are happening. These folks are serious about getting on with their mandate.

From our end, we have established a local, hospital-based advisory or steering committee to guide us through the developments. This group has provided the feedback on the proposed District Program and coordinated the development of the Aberdeen Oncology Clinic. We see this committee quickly evolving into the District Cancer Committee. In this regard, we fully support the proposed terms of reference as outline in Appendix C of the overall district program proposal. In fact, we see this committee as the key to the successful implementation of the program.

Benefits

First and foremost, we see the opportunity to participate in an evidence-based provincial program that should elevate both the quality and scope of treatment that Pictonians can expect.

Secondly, we see access to care, educational opportunities, and research being substantially improved.

And thirdly, as evidenced by today's Roundtable discussion, ***CCNS*** wants to move cancer care forward in a collaborative and partnership approach. The benefits of working together are several and, I believe, self-evident.

APPENDICES

APPENDIX ONE:
Mission Values and Vision of Cancer Care Nova Scotia

Cancer Care Nova Scotia

Cancer Care Nova Scotia

Mission

The purpose of *Cancer Care Nova Scotia* is to help achieve excellence in cancer prevention, treatment, care and research.

Values

In fulfilling our mission, *Cancer Care Nova Scotia* will:

- Display leadership
- Be centered on patients and families
- Support caregivers
- Demonstrate compassion, and integrity
- Value privacy, dignity and diversity
- Collaborate with others
- Build on existing strengths
- Use resources responsibly

Vision

Cancer Care Nova Scotia will reduce the effects of cancer on individuals and families through research, prevention and screening, and will lessen the fear of cancer through education and information.

All Nova Scotians, diagnosed with cancer, together with family, friends, and community, will find all aspects of cancer treatment and care excellent in quality, professional in delivery, compassionate in focus, and caring in spirit.

APPENDIX TWO:
Summary of Needs Assessment

Roundtable Needs Assessment: Summary of the Results

Background

On February 22, 2000, ***Cancer Care Nova Scotia*** (***CCNS***) faxed a cover letter and needs assessment to a sample of cancer care professionals and volunteers across the province (n=60). Thirty-five completed needs assessments were returned to ***CCNS*** (response rate = 58%).

Results

- Respondents were asked if holding discussions about a model for community cancer programs in Nova Scotia would be a reasonable focus for the Roundtable. Participants unanimously supported this theme.

- Respondents rated the importance of various possible components for the Roundtable agenda. Results are summarized in the following table*:

	Very Important	Somewhat Important	Not Important	No Response
Information about the development of the Canadian Cancer Strategy	22	9	1	1
Information about a community-based model of cancer care, and small group discussion about how it might be implemented	32	2	0	0
Information about ***Cancer Care Nova Scotia***	22	9	2	1
Display space for groups and organizations to showcase their programs	11	20	3	0
Structured time for participants from the same geographic region to discuss common issues	22	9	2	1
Discussion to identify effective ways for participants to work together on common issues.	33	1	0	0

**One respondent indicated that they did not "feel sufficiently familiar with the issues" to respond to the needs assessment, so they did not complete a form. Therefore, for the purpose of tabulating responses, the total number of responses is 34.*

In response to a question about the most important outcomes of the Roundtable, several themes emerged:

Collaborative Action: Develop a common understanding of the issues, establish priorities and initiate action plans.
Standards of Care: Improve standardized care throughout the province.
Equitable Access: Ensure equitable access to cancer care across the province.
Information Sharing: Need to share information about available services and resources, both to ensure better patient care and to ensure we are not duplicating the work of others.

APPENDIX THREE:
Roundtable Agenda

Cancer Care Nova Scotia

Cancer Care in Our Communities:

A Roundtable Discussion

June 7, 2000; 8:15 a.m. – 6:00 p.m.
Harbour View Holiday Inn, Wyse Road, Dartmouth, Nova Scotia

AGENDA

8:15 a.m.	Registration
8:30 a.m.	Welcome
8:45 a.m.	Overview of the Day
9:00 a.m.	Cancer Care in Our Communities: Across Canada
9:20 a.m.	Cancer Care in Our Communities: Proposed Model for Nova Scotia
9:40 a.m.	Working Session # 1: Response to the Proposal
10:30 a.m.	Break
10:45 a.m.	Working Session #1 Continued: Response to the Proposal
12:30 p.m.	Lunch (provided)
1:30 p.m.	Working Session #2: Implementing the Proposed Model in Nova Scotia Communities
2:45 p.m.	Working Together: Shared Solutions and Maintaining Accountability
3:00 p.m.	Break
3:15 p.m.	Working Session #3: Working Together: Challenges, Opportunities, Choices

APPENDIX FOUR:
Summary of Individual Comment Forms

Summary of Individual Comment Forms

During the Roundtable meeting, participants were provided with copies of "individual comment forms." If anyone felt that they did not have the opportunity to raise an issue or concern during the small group discussions, they were invited to fill out a form detailing their concern, and submit it with their evaluation form. In addition, one individual who was unable to attend the Roundtable asked that their concern be noted, so a form was completed on their behalf.

A few individuals commented on more then one issue on their form. The following is a synthesis of the fourteen individual comment forms that were received.

Oncology Nurse vs Chemotherapy Nurse

Three comment forms expressed the need to change the term "chemotherapy nurse" to "oncology nurse." It is believed that the term "oncology nurse" better describes the comprehensive care provided, since administering chemotherapy is only one component of the care

Patient-Centred Care

Two comment forms referred to the issue of patient-centered care. One individual expressed their belief that the definition of patient/family focus needs to be clarified even further in the development of the District cancer Program Model. The other comment suggested that the cancer system needs improvement in being "culturally-centered", in terms of policy, administration and delivery.

Prevention

Two individuals commented on the need to ensure that prevention and screening are high priority issues. One individual suggested that nurses should be supported to work in communities to do breast and cervical screening, smoking cessation and other preventative services.

Pediatric Cancer Care

Two comments were made requesting that the pediatric component of the cancer system be more clearly outlined, and one comment requested that when our documents refer to tertiary cancer centres, the IWK-Grace Health Centre needs to be included.

Stigmatization of Cancer Patients

It was suggested that the issue of stigmatization of cancer patients in the workforce needs to be addressed, perhaps in partnership with the Human Rights Commission. In the words of the individual who wrote the comment: "Individuals are having to suffer needlessly as a result of having to hide diagnosis/treatment so as not to suffer from lack of future career advancement opportunities, health insurance benefits under scrutiny, or perception of incapacity of cancer survivors. Obviously, I speak from experience."

Cancer Site Teams

One individual took exception to the term "cancer site team," considering the phrase to be insensitive and de-humanizing, as well as confusing (geographical site vs. cancer site).

Palliative Care

One individual suggested that cancer patients would benefit from having involvement with palliative care for support, symptom management, and coordination of care from diagnosis. Because the infrastructure for palliative

care exists already in many parts of the province, it could be utilized to support patients in their own communities without significantly increasing costs. It was noted that the perception of palliative care as a service only for the dying, is a barrier to accepting the resources and services that palliative has to offer.

Community Chemotherapy

It was noted by one participant that even though their accredited community hospital has provided chemotherapy service for more than 20 years, patients from their community are frequently told by their cancer specialist that they have to have chemotherapy in a major centre. The individual questioned why this was happening.

District Cancer Committees

One individual suggested that District Cancer Committees have "revolving" membership, so that members change every few years. This would allow for broader participation over time.

Prostate Screening

One individual asked when there will be a provincial prostate screening program in Nova Scotia.

Funding

One comment form contained a brief question about funding: "Is funding going to be there for every year after this?"

Meeting Facility

One individual requested that in future we try to use a meeting facility that contains technical equipment to aid the hearing impaired. The individual noted that all of the surrounding noise in the meeting room made it difficult for them to hear discussions.

APPENDIX FIVE:
Summary of Participant Evaluations

Summary of Participant Evaluations

Introduction

Sixty-six evaluation forms were returned at the end of the Roundtable meeting. The following summarizes the comments from the evaluation forms. The responses to open-ended questions (questions 1,2,3,5 and 6e) have been grouped by theme. Themes were created if three or more respondents made a similar comment. Themes are presented in summary tables below that also show the number of respondents who made comments related to each theme. A few sample comments from the evaluation forms are included on the left side of the page.

In some cases, respondents did not answer all questions or they provided more than one answer to a question. Therefore, the total number of responses for each question may not total 66. A compilation of all evaluation responses is available on request by contacting Heidi Little at 473-3485.

Comments about how the Roundtable met expectations:

"Good discussion involving several disciplines from cancer survivor to physicians to CCS to ***CCNS***."

"It gave me a voice in discussions."

"I am leaving with a better understanding of the program, which I will share with my colleagues in our rural area."

"Excellent cross section of participants."

"Effective method of communication and consensus building."

Summary of Responses: Questions About the Roundtable Meeting

The first question on the evaluation form asked participants to describe how the Roundtable met their expectations. Sixty-three people responded to this question.

Theme	*Number of Responses*
• Networking/open communication and dialogue	13
• Providing a wide variety of perspectives/diverse participation	11
• Providing information about ***Cancer Care Nova Scotia*** and the vision for the cancer system	11
• Allowing meaningful input into the development of the district model	10
• Providing a good process for discussion/organized approach	6
• Identifying common concerns and goals/sharing ideas	9

Comments about how the Roundtable did not meet expectations:

"Too long given the intensity of the work. The mind can only absorb what the seat can endure!"

"Where are the diminished human resources in this province going to find energy & dollars to truly move with this plan?"

"Would have liked to have had a few more questions answered re: timelines/next steps."

Participants were also asked to identify how the Roundtable did not meet their expectations. Twenty-four people responded to this question.

Theme	*Number of Responses*
• Too long/too much content for one day/tiring	7
• Did not address specific implementation issues/not sure what happens next	6

Comments about what participants felt was the greatest value of the Roundtable:

"Being heard without prejudice."

"Developing a shared vision for cancer care in Nova Scotia."

"Gave hope to real vision and growth in a troubled province."

"I think it helped to change people's image of ***CCNS*** to one of true collaboration."

Sixty-two people responded to the question: "What do you consider to be the greatest value of the Roundtable?"

Theme	***Number of Responses***
• Networking/communication	25
• Inclusion of a wide variety of stakeholders	15
• Opportunity to discuss common ideas, concerns, values and problems	13
• Opportunity to provide input into the model/***Cancer Care Nova Scotia***	9
• Consensus building/collaboration	8
• Increased awareness about ***Cancer Care Nova Scotia*** and its role	6

Question 5 of the evaluation form asked participants if they had any other comments to make about the Roundtable.

General comments:

"Let's work together to help provide a comprehensive cancer care program. Let's ensure enhancement of existing services – not duplications."

"Let's not be doing this task and have the results put on the shelf (a lot of past reports were never realized)."

"Greater emphasis on prevention programs and education."

"Looking forward to write up of today's sessions. Has to come in a timely manner to have value."

Theme	***Number of Responses***
• Excellent day/well organized event/good process	12
• Don't duplicate existing programs/build on existing programs, resources and volunteers	6
• Immediate action is needed to follow up on the work done at the Roundtable	4
• Day was long, especially for those travelling.	3

Summary of Responses: Questions about Planning for Future Roundtable Meetings

In response to the question: "do you think we should hold another Roundtable meeting in the future", sixty-two people answered yes, two people answered no, and two people did not respond. Those who responded 'yes' were asked to complete an additional series of questions to assist in planning the next Roundtable meeting.

The question "how often should Roundtables be held" resulted in a wide variety of answers, summarized below.

Proposed Frequency of Roundtable Meetings	*Number of Responses*
• Two times per year	17
• One time per year	15
• One or two times per year	7
• Twice a year through development phase, then annually	7
• As necessary	5
• Three times per year or more	4
• Once a year centrally, twice a year regionally	3
• Two to four times a year in districts	3

In terms of the length of the session, respondents generally preferred a full day session.

Length of Session	*Number of Responses*
• Full day session	29
• Two half day sessions (afternoon and following morning)	12
• Either of the above options are acceptable	17

Respondents indicated the days of the week on which they prefer to attend meetings. Several respondents indicated that any day is acceptable, so their responses are not included in the table below.

Day of the Week	*Number of Responses*
• Wednesdays	44
• Thursdays	36
• Tuesdays	31
• Mondays	22
• Fridays	18
• Saturdays	4
• Sundays	1

In answer to the question: "should Roundtables always be held in a central location, such as Dartmouth, or should they be moved around the province," twenty-nine people suggested that a central location was best, while fourteen people suggested that moving around the province is a better option. Numerous locations were suggested for the next meeting, with Truro and New Glasgow being the most frequently stated options.

Respondents were asked to suggest possible topics for the next Roundtable meeting. These ideas are summarized below.

Possible Topics for Next Roundtable Meeting	*Number of Responses*
• Update on progress/follow-up from today	24
• Develop details within the model/develop implementation and evaluation strategies for the model	15
• Prevention and screening update/planning	6
• Standards development	6
• Funding/resource plan to support model	6

APPENDIX SIX:
List of Participants

List of Participants

Charlotte Akerman Programs Coordinator Canadian Cancer Society 5826 South Street Halifax, NS B3H 1S6	**Phone:** 423-6183 **Fax:** 429-6563 **e-mail:**	Programs Coordinator, supportive care with the Canadian Cancer Society, NS Division. I work primarily with volunteers and patients and their families. My main role is the provide emotional support to patients and coordinate the volunteers who work emotional support programs of the CCS.
Mary Anderson Inverness Cons. Memorial Hospital PO Box 610 Inverness, NS B0E 1N0	**Phone:** **Fax:** **e-mail:**	
Nancy Archibald Northern Regional Coordinator Canadian Cancer Society 93 Howe Avenue Fall River, NS B2T 1H7	**Phone:** 860-1035 **Fax:** **e-mail:**	Provide information about cancer and cancer control. Provide leadership in cancer risk reduction and prevention. Enhance quality of life of people living with cancer through emotional support and patient services.
S.L. Barclay Chief of Staff Aberdeen Hospital 10 Abercrombie Road New Glasgow, NS B2H 1K1	**Phone:** 752-4177 **Fax:** 755-1917 **e-mail:**	Chief of Staff of Aberdeen Hospital, Family Physician.
Elizabeth Barker Director, Acute Care Nova Scotia Department of Health 1690 Hollis Street Halifax, NS B3J 2R8	**Phone:** 424-5667 **Fax:** 424-0550 **e-mail:** barkere.gov.ns.ca	
Rod Beresford Joint Action Group 320 Esplanade Sydney, NS B1P 7B9	**Phone:** 563-5584 **Fax:** 563-5240 **e-mail:** rberesford@uccb.ns.ca	Chair of the Health Studies Working Group of JAG; Health Studies mission is to study the impact of the Muggah Creek watershed on the human health of the community and to enhance its health by involving, educating and empowering the community through partnerships.

Beverly Braunmiller
Sydney Unit Administrator
Canadian Cancer Society
Sydney Unit, 54 Ferry Street
Sydney, NS B1P 6A3

Phone: 564-8263
Fax: 539-2526
e-mail:

I am the Sydney Unit Administrator for the Canadian Cancer Society. I also act as Patient Resources Representative at the Cape Breton Cancer Centre, assisting patients directly; and also assisting Cancer Society Volunteers throughout the Region, who provide financial assistance to patients receiving treatment at the Cape Breton Cancer Centre.

Gail Bruhm
Family Caregivers Association of NS
2615 Northwood Terrace
Halifax, NS B3K 3S5

Phone: 421-7390
Fax: 421-6313
e-mail: fcgans@nwood.ns.ca

The Family Caregivers Association of Nova Scotia is dedicated to the recognition and support of all who are caregiving to family or friends who are physically or mentally challenged, chronically ill or frail and elderly either at home or in a care facility. The Association promotes education about the significance of the caregivers role and their contributions to society and

Krista Burrill
Communications Officer
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As a communications officer with the Department of Health, I am frequently in a position to respond to questions and concerns from health care consumers, practitioners and members of the media. Cancer is among the most frequent topics of discussion and a priority area for government. As the province works to move health care closer to communities and improve service delivery, cancer care will continue to be a significant issue. Communicating the progress and efforts in cancer care delivery and reform is an important task requiring a partnership between DOH, ***CCNS*** and communities throughout the province. I'm pleased to

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Planing Unit
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Nancy Cameron
Strait Richmond Hospital
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Working as Palliative Care Coordinator, feel Palliative Care has an important part in Cancer Care continuum.

Janet Carver
Reg. Palliative Care Program
55 Regional Hospital
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Phone: 521-0081
Fax:
e-mail:

Lynda Casey
Clinical Site Manager
Digby General Hospital
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Digby, NS B0V 1A0

Phone: 245-2501
Fax: 245-2803
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Clinical Site Manager at Digby General Hospital, our community hospital would like to actively participate in a continuum of care for patients in our

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Public Health Services aim to improve the population's health by: Working in partnership with communities, families, and individuals to identify health needs and health potential. By supporting collective and individual action to prevent illness, protect and promote health, and achieve well-being. Public Health Services programs/services/initiatives aim to promote improved population health thereby reducing the risk of developing many chronic diseases and conditions, including certain types of cancer.

Kaye Marie Chisholm
Chemotherapy Nurse
St. Martha's Regional Hospital
25 Bay Street
Antigonish, NS B2G 2G5

Phone: 863-2830 (4240)
Fax: 867-4432
e-mail:

I am the chemotherapy nurse at St. Martha's Regional Hospital in Antigonish. I also work with the Palliative Care Program.

Tricia Cochrane
Manager
Soldier's Memorial Hospital
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Middleton, NS B0S 1P0

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Fax: 825-0599
e-mail: cochrat.smh@wrhb.org

As manager of a community hospital it is important that I understand the "big picture" of cancer care and support/encourage appropriate components of cancer care as close as possible to the patient's home community.

Anne Cogdon
Director of Community Health
Central Regional Health Board
Dartmouth General Hospital, 325 Pleasant Street
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e-mail: cogdona@crhb.ns.ca

It is imperative that Central Regional Health Board partner with Cancer Care Nova Scotia to ensure appropriate and effective cancer prevention, treatment and care for the population of our region.

Elizabeth Cooper
Clinical Nurse Specialist
IWK/Grace Health Centre
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Bedford, NS B4A 3N9

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e-mail: ecooper@iwkgrace.ns.ca

I am the Clinical Nurse Specialist for Pediatric Oncology at the IWK/Grace Health Centre. I work with families who have a child with cancer and thus believe that a system of cancer care must be responsive to the needs of all families in NS.

Louise Cottreau
Palliative Care Team
Annapolis Community Health Centre
RR#1
Granville Ferry, NS B0S 1K0

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My interest with cancer care delivery is very strong because we deal with many through our involvement during the process of dying. It hopefully will give me more understanding in relation to delivery of such care.

Ginny Cronin
Breast Cancer Action Nova Scotia
15 Forestside Crescent
Halifax, NS B3M 1M5

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As a member of Breast Cancer Action Nova Scotia and as a person with breast cancer I am interested in issues which affect society's response to breast cancer. Among these issues are the environmental causes of breast cancer, early diagnosis, and optimum patient care.

Bruce Crump
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Joanne Cumminger
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Chemotherapy Nurse at Aberdeen Hospital. Facilitator Women Alike Breast Cancer Group. Living with Cancer Support Group.

Peggy Davison
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Sandra Decaire
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Eastern Shore Palliative Care
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Bonnie Eagle
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e-mail:

As the current CSM of HSASS, I would like to be a participant in the process of improving and strengthening existing services. This includes communication referrals from the QEII back to SSRH, avoidance of duplicated diagnostic services, funding, guidelines for treatment, etc.

Vicki Elliott-Lopez
Western Regional Coordinator
Canadian Cancer Society
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Western Regional Coordinator - works with volunteers to deliver and develop CCS programs and services across the Western Region. We are currently concentrating on primary prevention and focus on partnership development with other related organizations.

Ethel Ells
Valley Regional Hospital
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Kentville, NS B4N 5E3

Phone: 679-2657 (2835)
Fax: 679-0557
e-mail:

My work involves giving chemotherapy to both outpatients and inpatients at Valley Regional Hospital. Anything that would be helpful for them and their care and their families or significant others - total family/patient support systems.

Jane Farquharson
Director-Heart Health Nova Scotia
Heart Health Nova Scotia
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Many cancers can be prevented. An integrated, comprehensive approach to risk factor reduction (tobacco, activity, diet and sun) would greatly improve the health of many NS residents. Effective partnerships (between the cancer sector, heart health, diabetes, lung, public health, addiction services, school boards, community health boards, district health authorities) are essential to create a system that works. A major focus of a community model for cancer prevention and care needs to be health promotion and prevention. To make a difference we need community action, policies, services and programs.

Gerry Farrell
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Palliative Care Director, interested in the GP fellowship program.

Patrick Flinn
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Mary Foshay
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I am presently an RN, and the Care Team Coordinator for Hematology/Oncology at the IWK/Grace Health Centre. My interest is obviously in the pediatric component of ***Cancer Care Nova Scotia***.

Andrea Gardner
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Involved as a pharmacist consultant with Rural Palliative Care Project currently underway in the Northern Region. Involved with the provision of chemotherapy to patients at Aberdeen Hospital, New Glasgow.

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As a retired member of my community, I am very interested in helping improve the system that can provide better cancer services to cancer patients, their family and friends. I have gained a variety of organizational experience as a community volunteer with groups such as the Kiwanis Club, Property Owner's Association, a Community Health Board and a local CCS Unit. I feel this initiative has the potential to improve communications, coordination and

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The Canadian Breast Cancer Foundation is dedicated to supporting the advancement of breast cancer research, education, diagnosis and treatment.

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President of local Cancer Society, member for 14 years. Steering Committee for Cancer Society and Revenue Development for Cancer Society.

Mary Ellen Gurnham
Director Oncology Services
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Christine Heggelin
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I am Nurse Manager of inpatient Radiation and Gynecologic Oncology, QEII, 5A Centennial. I work with many experts who are passionate and competent in their care giving. I am also a Nova Scotian who understands that there is much work to be done by all of us to improve our own health and to prevent cancer in

Jeslyn Hendsbee
Palliative Care Coordinator
Inverness Cons. Memorial Hospital
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Phone: 258-1927
Fax: 258-3058
e-mail:

Douglas Henshaw
951 Route 360 North
RR#5
Berwick, NS B0P 1E0

Phone:
Fax:
e-mail:

Earle Hiltz
President
Nova Scotia Division Canadian Cancer Society
5826 South Street, #1
Halifax, NS B3H 1S6

Phone: 423-6183
Fax: 429-6563
e-mail: earle.hiltz@ns.sympatico.ca

President of the Nova Scotia Division, Canadian Cancer Society. Chairman of the Board of Directors who direct and facilitate the goals of the Nova Scotia Division and its operation plan. The Division's mission is the eradication of cancer and the enhancement of the quality of life of people living with cancer.

Karen Hoben
Guysborough Memorial Hospital
PO Box 170
Guysborough, NS B0H 1N0

Phone: 533-3702
Fax: 533-4066
e-mail:

Nan Holden
Clinical Site Manager
Roseway Hospital
PO Box 610
Shelburne, NS B0T 1W0

Phone: 875-3011
Fax: 875-1580
e-mail:

As clinical site manager of Roseway Hospital in Shelburne, I am most concerned about access to services. Significant distance to service outside the community create hardships especially when frequent travel is required. Care providers must develop systems through new technologies to reduce travel needs while ensuring timely communication.

Ann Hopkins
Dept. of National Defense
PO Box 9900, Stn. Forces
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Phone:
Fax:
e-mail:

Bonnie Hostrawser
Canadian Cancer Society
#1-5826 South Street
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Fax: 429-6563
e-mail: nstn3332@fox.nstn.ca

The Canadian Cancer Society is committed to providing community service in the areas of cancer prevention, advocacy, information provision and support to cancer patients.

Heather Jewers
Nurse Consultant
St. Martha's Regional Hospital
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Antigonish, NS B2G 2G5

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Involved in Palliative Care Program at St. Martha's Regional Hospital as a Nurse Consultant. Developed proposal for implementation of the Cancer Support Clinic within the Palliative Care and Oncology programs at St. Martha's. This clinic was started April 5/00 to provide support and coordination of care for cancer patients from diagnosis.

David Jones
Canadian Cancer Society
54 Fenwood Road
Halifax, NS B3N 1G8

Phone: 475-3510
Fax: 475-3511
e-mail: wendy_david.jones@ns.sympatico.ca

Canadian Cancer Care - Nova Scotia Division. Board of Directors. Chair Programs Committee.

Janet Knox
Continuing Care Program
IWK Grace Health Centre
5850/5980 University Avenue
Halifax, NS B3J 3G9

Phone: 428-5931
Fax: 428-3206
e-mail: jknox@iwkgrace.ns.ca

Program Director, Children's Acute and Continuing Care Program which includes the Children's Hematology/Oncology Care Team.

Michelle Landry
Confederacy of Mainland Mi'kmaq
1854 Kings Road
Sydney River, NS B1L 1C5

Phone: 564-1854
Fax:
e-mail:

Shelagh Leahey
Western Regional Health Board
312-50 Vancouver Street
Yarmouth, NS B5A 2P4
Phone: 742-7596
Fax: 742-0072
e-mail:
Represent WRHB as interested General Practitioner doing front line work with cancer survivors and their families.

Kathy Little
Regional Representative - Cumberland County
Canadian Cancer Society
RR#1
Wentworth, NS B0M 1Z0
Phone: 548-2987
Fax:
e-mail: 4klittle@istar.ca
As volunteer Regional Representative for Cumberland County with the Canadian Cancer Society, I act as a resource person to the CCS units in Cumberland County and attend unit functions. I also participate as a member of the board of Directors of CCS on behalf of the units and act as the official spokesperson.

Cathy Logan
RN
Duncan MacMillan Nursing Home
PO Box 68
Sheet Harbour, NS B0J 3B0
Phone: 885-3631
Fax: 885-3289
e-mail:

Claudia Lutz
Digby General Hospital
PO Box 820
Digby, NS B0V 1A0
Phone: 245-2501
Fax: 245-2803
e-mail:
Work in ambulatory care setting that provides chemotherapy.

Shaun MacCormick
Medical Director
Northern Regional Health Board
44 Inglis Place, Suite 6
Truro, NS B2N 4B4
Phone: 897-6265
Fax: 893-0250
e-mail: smaccormick@nrhb.ns.ca
Medical Director for Northern Regional Health Board, experience as a family practitioner and active in palliative care.

Joan MacDonald
Canadian Cancer Society
117 Audrey Drive
Bridgewater, NS B4V 2Z3
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Fax: 543-8582
e-mail: hub@ns.sympatico.ca
Chairperson Canadian Cancer Society Emotional Support and Patient Services, Bridgewater Unit Volunteer 12 years.

David MacDonald
Health Canada
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Dennis MacDonald
Aberdeen Regional Hospital
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Phone: 752-7600 (4190)
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Registered nurse, palliative care coordinator, board member - Nova Scotia Palliative Care Association.

Hubert MacDonald
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Division Vice President of Canadian Cancer Society, Bridgewater Unit Volunteer 7 years.

Patricia MacEwan
Home Care Nova Scotia
Aberdeen Professional Centre, 828 East River Road
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Phone: 928-3611
Fax: 752-3532
e-mail:

Work for Home Care Nova Scotia and am part of the Rural Palliative Home Care Project. Background education in social work and have been a cancer care

Steve Machat
Canadian Cancer Society
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Teresa MacInnis
Facility Manager
St. Mary's Memorial Hospital
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Sherbrooke, NS B0J 3C0

Phone: 522-2882
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e-mail:

Eight bed acute care community hospital. Family physicians provide diagnosis and referral of persons with cancer. Palliative Care program provides support throughout illness trajectory. Multidisciplinary care team provides care of cancer patients from community.

Maureen MacIntyre
Nova Scotia Cancer Registry
Room 569 - Bethune Building
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Phone: 473-6084
Fax: 473-4425
e-mail:

Responsible for management of the Nova Scotia Cancer Registry. Key interest is the utilization of information systems to facilitate cancer control strategies.

Susan MacLeod
Communications Coordinator
Cancer Care Nova Scotia
1278 Tower Rd Bethune 540
Halifax, NS B3H 2Y9

Phone: 473-2932
Fax: 473-4631
e-mail: ccjtp@qe2-hsc.ns.ca

Jane MacLeod Strait Richmond Hospital RR#1 Cleveland, NS B0E 1J0	**Phone:** 625-1691 **Fax:** 625-3804 **e-mail:**	Facilitatior of Living with Cancer Group in Port Hawkesbury.
Shirley MacLeod Regional Rep-Central Area Canadian Cancer Society 52 Eagle Lane Dartmouth, NS B2V 2G5	**Phone:** 462-7790 **Fax:** **e-mail:** chiefmac@ns.sympatico.ca	I am a member of the board of the Nova Scotia Division of the Canadian Cancer Society. I am the board liaison for 9 units (CCS) in the Central Region.
Elaine MacMaster Guysborough Memorial Hospital PO Box 170 Guysborough, NS B0H 1N0	**Phone:** 533-3702 **Fax:** 533-4066 **e-mail:**	
Clare MacQuarrie Facility Manager Inverness Cons.Memorial Hospital PO Box 610, Church Street Inverness, NS B0E 1N0	**Phone:** 258-1901 **Fax:** 258-3025 **e-mail:** cmacquarrie.ich@erhb.ns.ca	
Anne Marie Maloney Central Regional Health Board 77 Silver Terrace Bedford, NS B4A 3V9	**Phone:** 865-2219 **Fax:** **e-mail:** maloneyam@crhb.ns.ca	Locally, in Hants County, I am Chair of the Palliative Care Advisory Committee. In my role at CRHB I am responsible for integration of services, at a community and facility level.
Karen Mann Division Medical Education Dalhousie, Clinical Research Centre, Rm. C112 Halifax, NS	**Phone:** 494-1884 **Fax:** 494-2278 **e-mail:** karen.mann@dal.ca	
Elizabeth McLean Canadian Cancer Society, Pictou East Island, RR#1 Eureka, NS B0K 1B0	**Phone:** 923-2565 **Fax:** **e-mail:**	The volunteer component of health care.

Jim Meikle
Cancer Care Nova Scotia
108 Birch Street, PO Box 863
Stellarton, NS B0K 1S0

Phone: 752-0993
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e-mail: jim.meikle@ns.sympatico.ca

I am a Board Member for ***Cancer Care Nova Scotia*** and presently serve as chair of the Communications Working Group for ***CCNS***. I have a background in public education and am currently involved in promoting policies and standards for cancer care in cooperation with Community Health Boards.

Ann Miller
Central Regional Health Board
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Central Regional Health Board is involved in the delivery of care for individuals and families experiencing cancer. The organization is committed to participating development of a full continuum of care, emphasizing the importance of promotion and prevention with initiative and community-based primary care.

Mary Frances Moriarty
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I have been in General Practice for 22 years, do both in hospital and at home palliative care as well as supporting people and their families from diagnosis of cancer to it's conclusion.

Linda Muir
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President of Hants West Unit, Canadian Cancer Society. Healthcare Facility Manager - Hants Community Hospital. Registered nurse with areas of interest in surgical care and oncology.

Debbie Muise
Charge Nurse
Twin Oaks Hospital
Musquodoboit Harbour, NS B0J 2L0

Phone: 889-4107
Fax: 889-2470
e-mail:

Charge Nurse at Twin Oaks Hospital. Many patients with cancer - palliative care - work closely with HCNS (discharge planning).

Anne Murray
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Jeffrey Nguyen
President NSCMH
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Providing information on culturally responsive health care to multidisciplinary service providers. Working toward removing cultural and language barriers of assessing health services by marginalized ethno-cultural clients. Expertise on cross cultural mental health programs/services, provincially and nationally.

Debbie Oliver
Aberdeen Regional Hospital
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Annette Penney
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I have worked in pediatric oncology as a nurse at the IWK/Grace Health Centre for almost twenty years. I am an active member of the Canadian Association of Nurses in Oncology, and I am president of the local chapter of CANO.

Jill Petrella
Quality Coordinator
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Kimberley Pitts
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I am interested in how the cancer system will affect research patients.

Charlene Porter
Palliative Care Coordinator
St. Mary's Memorial Hospital
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Eight bed acute care community hospital. Family physicians provide diagnosis and referral of persons with cancer. Palliative Care program provides support throughout illness trajectory. Multidisciplinary care team provides care of cancer patients from community.

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Karen Pyra
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Katheryn Rawding
Annapolis Community Health Palliative Care Unit
RR#1
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Phone: 532-2446
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I work with a Palliative Care Unit at the Annapolis Community Health Centre. We provide end of life care for patients in our community who are unable to stay at home. This is a privately funded unit. We are interested in what is being planned by the province and regional units to advance cancer care.

Leonard Reyno
Head, Division of Medical Oncology
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Medical Oncologist, Head - Division of Medical Oncology QEII, Associate Professor - Dalhousie University

Rose Richardson
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Mary Ross
Facility Manager
Strait Richmond Hospital
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I am facility manager at SR Hospital. Besides providing therapeutic and palliative care to the people of our community, we also are active in preventative care and promotion of healthy living. We are one of the pilot sites of the NS Gyn. Screening project and would like very much to expand this to men's health

Marguerite Rowe
Regional Director Clinical Program
Western Regional Health Board
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To foster collaboration between the Western Region healthcare providers and ***Cancer Care Nova Scotia*** in the provision of quality care for cancer treatment to the residents served.

Mary Russell
Director, Community Health
Central Regional Health Board
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Director, Community Health, Halifax Region responsible for supporting the Community Health Boards in the Halifax area as well as regional health planning. Ensuring appropriate cancer care services are available and accessible is a high priority in our communities.

Bonnie Salsman
Director of Pharmacy
QEII Health Sciences Centre
1796 Summer Street, NHI Rm. 2417
Halifax, NS B3H 3A7

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e-mail:rxbms@qe2-hsc.ns.ca

I am currently Director of Pharmacy at the QEII HSC and in this role have worked closely with the NSCC and other oncology treatment areas on issues related to systemic therapy for oncology patients. I am interested in issues such as accessibility of care, maintenance of standards, and development and implementation of evidence-based guidelines for care.

Pauline Samson
Strait Richmond Hospital
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Cleveland, NS B0E 1J0

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e-mail:

Working on the GYN Screening Project which has recently received funding through ***Cancer Care Nova Scotia***.

Sheila Scaravelli
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As a senior patient care system administration my interest is in gaining the necessary information to best allocate required resources to enhance service availability in our catchment area. I am also interested in establishing a network of contacts to support consistent application of standards for cancer care in our

Dianna Schreuer
Patient Navigator
Nova Scotia Breast Screening Program
3036A Dickson Bldg., 1278 Tower Road
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Patient Navigator Nova Scotia Breast Screening Program, Breast Cancer

Marlene Sellon
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Judy Simpson
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I am the QEII Palliative Care Program Educator and the President of the Nova Scotia Hospice Palliative Care Association (NSHPCA). I recently completed a seven-year term on the Board of the Canadian Association of Psychosocial Oncology. Over my 26 years in nursing, I have had a long-standing interest in cancer care, specifically in the area of patient/family psychosocial and supportive care. In my role as president of NSHPCA, I have an interest in supporting collaboration between NSHPCA and ***Cancer Care Nova Scotia***.

Carol Smillie
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Cancer Care Nova Scotia
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Norah Stephen
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Victoria Sullivan
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Nurse Program Manager at the Nova Scotia Cancer Centre at the QEII HSC. As someone who has been involved in cancer care in Nova Scotia for the past 12 years, I am interested in the further development of cancer care in this province to better meet Nova Scotian's needs.

Maureen Summers Canadian Cancer Society 5826 South Street, #1 Halifax, NS B0J 3J0	**Phone:** 423-6183 **Fax:** 429-6563 **e-mail:** mscancer@istar.ca	Executive Director, Canadian Cancer Society Nova Scotia Division.
Elizabeth Tappen Living With Cancer Group Box 1514 Greenwood, NS B0P 1N0	**Phone:** 765-2421 **Fax:** 765-9411 **e-mail:**	Personal interest as a cancer survivor, in the needs of the patient other than medical. I.e. information, not feel like a number, support system, data collection
Gordon Thomason Halifax Regional Prostate Cancer Support Group 302-5293 Green Street Halifax, NS B3H 1N6	**Phone:** 425-6473 **Fax:** **e-mail:**	Prostate Cancer Survivor. Member of: Halifax Regional Support Group, CCS Peer Support Group, Prostate Cancer Information Working Group.
Theresa Marie Underhill Chief Operating Officer ***Cancer Care Nova Scotia*** 1278 Tower Rd Bethune 540 Halifax, NS B3H 2Y9	**Phone:** 473-4638 **Fax:** 473-4631 **e-mail:** cckdp@qe2-hsc.ns.ca	
Martha Underwood Palliative Care Nurse North Cumberland Memorial Hospital Pugwash, NS B0K 1L0	**Phone:** 243-2521 **Fax:** 243-2941 **e-mail:**	Palliative Care Consultation Nurse at the North Cumberland Memorial Hospital as well as Staff Nurse caring for people and their families living with or dying from cancer.
Linda Verlinden Palliative Care Coordinator Twin Oaks Hospital RR#2 Musquodoboit Harbour, NS B0J 2L0	**Phone:** 889-4100 **Fax:** 889-2470 **e-mail:**	Palliative Care Coordinator, Marine Drive Palliative Care Association.
Shawn White Canadian Cancer Society 102-238 Brownlow Avenue Dartmouth, NS B3B 1Y2	**Phone:** 468-3689 **Fax:** 468-2174 **e-mail:** sw17010@glaxowellcome.ca	Metro location, but interests are all Nova Scotia. Accessibility of patients to cancer treatments and cancer prevention.